CM: Hello. Welcome to Doctor Informed, the new podcast from the BMJ, created in collaboration with THIS Institute and sponsored by Medical Protection.

Doctor Informed tries to take you beyond medical knowledge. We're going to be delving into all the bits of work in a hospital that, as you progress through your career as a doctor, you're going to find you have responsibility for but aren't necessarily prepared for.

We're going to be exploring teams, team dynamics, how concepts like voice, i.e. giving people the space and confidence to speak up can be fostered. We'll be looking at how unconscious and conscious behaviours can create cultures that harm both the staff working in the hospitals and the patients they care for.

I'm Clara Munro, a surgical trainee in the North East of England and I'll be your host through the podcast. If you heard our trailer, you'll have heard Jenni Burt from THIS Institute. Jenni will be joining me for a lot of the episodes and we'll be joined by special guests as well.

But in this first one, we're taking a wide view and have turned to two experts. They'll give us an insight into the scope of what we're talking about and the patterns that become apparent when things go wrong in a hospital.

You'll hear from Bill Kirkup, who is often been at the sharp and very pointy end of healthcare. He has led investigations where things have gone disastrously wrong both inside and outside of hospitals.

You'll also hear from Mary Dixon-Woods who heads THIS Institute. Mary has extensively studied healthcare system and leads research to generate evidence for improving quality and safety of healthcare.

Firstly, though, here's Bill.

BK: I'm Bill Kirkup. I trained in medicine and practiced as a clinician for about 10 years. And then switched into public health for family reasons and had a career in Health Service management and public health up until 2010, when I retired from full-time practice.

But I was asked to do an investigation and then another investigation. And I ended up spending the last 11 years being involved in one sort of investigation or another, into situations where things had gone pretty badly wrong. I have to say that the work that I've done, I sometimes describe it as a walk on the wild side because it hasn't been into typical trust situations or clinical situations, it's been where things have gone badly wrong.

But I do think that there is a lot of potential learning from those situations. Okay, maybe you don't see the full picture of that too often but you do see, and I've had a number of people say this to me, you do see elements of it in an awful lot of places. And that's why I think it's been worth doing.

So what have I done? I was involved in investigating children's heart surgery deaths in Oxford, where something had gone wrong when they tried to expand the unit and they tried not to tell anybody about it until they had a whistle-blower.

I was involved in the Hillsborough Independent Panel, providing the medical advice to the review of records that, I suppose, exposed the cover-up that there had been following Hillsborough that had persisted, astonishingly, for 25 years.

And I did an investigation into Jimmy Saville's activities in Broadmoor Hospital. The Morecambe Bay investigation into a systemic series of failings in the maternity unit. Liverpool Community, Gosport Independent Panel. And I'm currently involved in doing the investigation into East Kent Maternity Services and some further work in Liverpool.

So that's me.

CM: Just you. Quite the CV you've got there, Bill [laugh]. I mean, full disclosure to the listeners, we have obviously had conversations before. One of the things that you said that struck me as a clinician and that I think about over and over again, is that I remember you saying to me, sometimes when I start to do these investigations and look into things, you could almost write the report before you've done the investigation because the same patterns recur.

BK: Let me start with my experiences. Because I would wish that the situation had changed but I know, from talking to a lot of people at all sorts of levels in the Health Service, including some trainee doctors, that it hasn't or at least it hasn't changed everywhere.

My first experience of witnessing something badly wrong was actually when I was working as a ward orderly in a break before I started medical school. And I saw a poor, elderly patient who had ulcerative colitis and advanced dementia being appallingly treated, including some physical violence. And did I have a clue what to do about that? Not the foggiest notion. And so to my great shame and distress, I didn't do anything.

And I…therefore, I'm very sympathetic to anybody who finds themselves in that position and simply doesn't know how to handle it or what to do about it. My excuse was that I was only 18 at the time but, you know, I'm not a 100 per cent confident I would have done much better years later.

When I was a trainee, which I spent a fair time doing in clinical practice, I did make mistakes and people suffered in consequence. And I wish somebody had told me in advance that that would happen but nobody did. Very much the impression was given that you had to be infallible, anybody who blundered was, you know, letting everybody down, including themselves and it wasn't allowed.

And in practice, I knew the reaction to something going wrong from the consultants that I've worked with. And I wouldn't want to put all of them in the same category but, you know, the majority would be intensely critical and wouldn't be supportive. They wouldn't understand that you were feeling it as much as anybody else. Let me rephrase that. You don't feel it as much as the patient who's being harmed, of course you don't, but you feel it very acutely.

I would, frankly, have feared for my future career because these were the people who were going to give me the reference for the next job that I do at the next level to progress. This was before the days of STs.

And so, the overwhelming pressure was a) to explain it away and b) to not raise it to anybody's attention. And that shouldn't happen. You shouldn't feel like that. You should feel able to say, actually, you know, I was doing this list this afternoon and there was a real problem with the Diathermy machines, they wouldn't function. And I didn't know exactly what to do and I should have known. I should have known I should stop the procedure and make sure that I got a new Diathermy machine but I didn't. And so the procedure that I was doing failed as a result of that.

But I absolutely would not have felt supported in trying to raise that sort of message at all. And I wish that wasn't the case anymore, I wish it had changed but I don't think it has, not sufficiently anyway.

Gosh, you can tell that it still affects me all those years ago, can't you?

CM: Yeah. Thank you so much for sharing that, Bill, because, I mean, God, I'm feeling…I'm sure most people listening to this who are trainees or, you know, worked as doctors will think…I mean, all of us still, I'm sure, wake up at nights in the night and think about those experiences, big and small. Yeah.

BK: Absolutely. I think that the system's response in some trusts is still awful. And that's why we end up with some really, really difficult cases because they simply don't know how to handle problems where team working has broken down. There are hierarchical problems in some clinical units. There are interprofessional rivalries. I mean, that particularly occurs in maternity services but it's by no means restricted to maternity services that team working doesn't function effectively.

And we don't really have, I don't think, much understanding of what you do in those kind of circumstances. There is a growing body of science about how to develop team working. Great but what do you do when it's catastrophically gone wrong? You have a bunch of individuals who, as I've seen in the past, will turn and walk in the opposite direction when somebody comes down the corridor towards them. You know, how do you put that right?

CM: And Bill, we're talking about what sounds like individual behaviours here but what we've learnt from lots of other things is that individuals work within a system and, you know, systemic problems that can lead to lots of poor outcomes.

BK: Yes. I think it's clear that although all of these things start with individual clinicians interacting with individual patients, of course they do, that's what the Health Service is about, that is not where the problems lie. It almost never is where the problems lie. We all know that errors happen. It's a part of life, it's a part of clinical practice too. It's even more difficult when it happens in clinical practice because you feel awful about it as a clinician that there's a patient and a family who have potentially been harmed here.

But the issue is not about the error, the issue is about how that is then dealt with. And the first problem is in admitting it and investigating it and knowing that people are going to take the right approach to it. And if you feel that you can trust your colleagues and the people who you work for to do that openly and sympathetically and support you through a difficult process, then you're much more likely to get a better outcome for everybody who's concerned, the clinician and also that family who are desperate to know the answers.

If, on the other hand, you feel that you'll be criticised for making a mistake and you will maybe be subject to further procedures either from the trust or from regulators like the GMC, the whole process becomes closed and polarised. People don't learn, so the same mistakes may happen again to somebody else in the future. And then you're starting to see the build-up of what can become a bad, systemic problem. It's about the processes and the human factors really around how you deal with something that’s gone wrong in the first place.

At the full development of one of these horror stories that I've been mentioning, that I've been involved with in the past, you know, that has become endemic throughout an entire service and sometimes an entire trust. And when you're dealing with that, when you're in that situation, you know, it's pretty difficult to see how you get out of it.

It's not…when you're early on in that kind of process of things going wrong, I've said before maybe that it's a question of realising that you're on the right track and switching the points and getting back on the right track. But if you leave it past that point until the behaviour has become embedded and everybody is working in a climate of fear and suspicion, which is very often the case in those kind of trusts, you know, it's a train crash. You're trying to put the whole thing back onto the rails that it's left some time ago, much, much more difficult.

CM: Do you think that those are patterns that are specific to healthcare or do you think that you've seen them in other organisations as well?

BK: No, I don't think it's unique to healthcare. I think that a lot of this is understandable patterns of human behaviour, understandable but not necessarily desirable patterns of human behaviour. I think that part of the issue in healthcare is that it's very easy for everything to become much more fraught than in other situations but all of the same traits are visible in other organisations.

For instance, in the response to the Hillsborough Disaster, you know, it wasn't me, it was all the fault of somebody else, let's find somebody to blame, it was drunken, ticketless fans. A very similar sort of reaction to something horrendous going wrong on an individual's watch.

And I think that at an organisational level, we have this phrase now which is reputation management, it seems to me it's a thing that every organisation reaches for when they're under public scrutiny, public criticism. The first thing you think of is not have we done something wrong here and how can we put it right? The first reaction is, how can we protect our reputation?

And too often, the easy response to that, the first response to that is deflection, cover-up, denial, which really doesn't help the people who have been harmed as a result of this. It's completely inimical to their wellbeing and in some, it simply pushes them harder to make sure that these things do come to light.

CM: Now this could be a very gloomy conversation and obviously, we've been talking about investigations that you've done, which are based on very tragic events. But those investigations aren't always the end of things. The hospitals you look at, do they change, do they get better, do they improve? Have you seen some good examples of that and how that's been done?

BK: Yeah, okay. I don't want to use a particular example but if I could talk in generalities. Yes, I have seen some remarkable transformations that have occurred. And I think that the key first step is actually that people are able to admit the size and nature of the problem. Because very often, your first response is, you know, people have got this wrong, it's not as bad, there aren't as many cases as you thought. We've seen all of those responses play out in recent cases.

But if you can demonstrate clearly and convincingly that actually, you know, it was as bad, there were some really serious problems here, this needs to be fixed. If you can get people to that point, then it is absolutely brilliant to see what they can then do with that in turning around what's been a very poor and very difficult service.

And the first people to say that's marvellous, you've been transformational here are the families who have been affected in the first place. And the second group of people to say that are the staff working there, who now say this is a much happier place to be, actually we like coming into work better now because it feels positive, there's friendliness, there's people that are

treated with respect. But it didn't used to be like that. It works to everybody's benefit.

But I think the first step is admitting is the size and nature of the problem. Without that, you're forever trying to stick sticking plasters on and say, oh, it wasn't really that bad, you know, we'll just carry on.

S: [Advertisement]

CM: So I suppose when I hear Bill's stories and I hear about Bill reflecting on his experiences, I think they're similar to stuff that I've experienced on the ward and maybe a lot of doctors have experienced on the ward. When I see those patterns emerging, I personally don't always know how to stop them recurring And a lot of the time, if I'm completely honest, I feel like it's an awful lot of effort and I don't really have the tools or resources to do it. But then I think you hear some of Bill's stories and you think, no, maybe I should be doing something about this.

So you might not realise because until I started doing the research for this podcast, I don't think that I did either, but there is a whole world of research out there about stuff that actually works and evidence that people have compiled. One of these such people is Mary Dixon-Woods. She's a Director of THIS Institute. So as I say, I'm going to hand over to her now.

MD-W: Great. Thanks very much, Clara.

So I'm Mary Dixon-Woods and I direct The Healthcare Improvement Students Institute, known as THIS Institute. It was set up with a very generous grant from the Health Foundation about four and a half years ago. And its mission is to improve the evidence base for improving quality and safety in healthcare. That sounds like a very grand ambition. It's a very important one because although problems in quality and safety are very common, the evidence on how to address them has remained pretty weak. So that's our mission.

In terms of myself, I'm originally a social scientist. I've had a rather varied career. In fact, I started as a civil servant and that was very interesting because it gave me a lot of insight into policy processes. And I trained actually in communications for a while as well. And my degree…my PhD degree was on communication with patients.

I then spent 22 years in Leicester University, where I had a role in the medical school and was very involved in medical education, very interested in that side of things, and built up a group using social science methods to research issues of quality and safety in healthcare. I was also an editor at BMJ quality and safety for around 20 years and moved to Cambridge in 2016.

CM: I had a chat with Bill last Friday, Bill Kirkup And he was so candid in his reflections as well, I mean, some of the things he said were just real

lightbulb moments for me. And I expect people listening to this podcast may well feel the same.

I think one of the things that he discussed and one of the things that we've discussed before is problems relating to patient safety are often recurring, so they often fall into patterns. And that's certainly what Bill felt when he goes and does these investigations, interestingly, both in and outside healthcare.

And I wondered whether your research at THIS kind of aligned with that and what it tells you about these problems or patterns that are often repeated in hospital?

MD-W: Thank you very much, Clara. I think it's absolutely the case that many problems in patient safety demonstrate these recurring patterns. They're very predictable. And it's also noticeable that they occur in areas outside healthcare. There's a very long history of study of accident investigation going back to really the 1960s and very, very interesting literature that talks about the importance of danger and that analyses the antecedents, the things, the red flags that means things were already beginning to go wrong.

And you can see it in everything from, you know, the Deepwater Horizon Disaster, through to the NASA failures and the patterns are very vivid and they're very recurrent. And you see many of the same things happening in relation to patient safety.

They happen really for a whole set of reasons and one of them is that the kinds of intelligence that we're gathering about what is going wrong and also what's going right are not always very well-suited to real-time monitoring of safety conditions. They're very often red flags that things are beginning to go wrong.

And in the really excellent work that Diane Vaughan did on the Challenger Disaster, she described a phenomenon she called normalisation of deviance. What it's describing is that over time, little lapses start to be tolerated and they become normalised and just…everybody just kind of gives up even noticing them or they can't…it's no longer visible or people feel they can no longer talk about them because it's just normal.

As doctors and maybe trainees who are moving around hospitals, they see this all the time. They would see, oh, well, this is how we do things here. And you go to somewhere else and it's completely different but it's the way they do it there. And you're in the system like for such a short period of time, it can be very difficult to challenge it.

CM: Some of these patterns, especially when we're looking at things like hierarchy, group dynamic, how we function as a little cog in a big machine, they can be really, really complex. And as an individual in that system, it can feel like there's no autonomy, there's no…there's nothing that you can do to change things.

How does your research at THIS help to get beyond observing that complex problem and move towards addressing it in more of a practical way?

MD-W: Okay, I'm going to…thank you very much, that's a really interesting question which I'm going to take in two parts. I think one of your questions is about how do we create the culture or conditions where people can speak up. And the second question then about the culture or conditions for making change happen. They're two linked but not quite the same thing.

So I'll start with speaking up. And this is an area where there has been a very impressive body of research and it essentially shows that you can improve speaking up through a set of very specific behaviours, which has to be shown by leadership. And this taken together, this set of behaviours is known as creating conditions for psychological safety.

And the construct was developed by Amy Edmondson at Harvard but there's now very nice literature that's grown up around it. And in THIS Institute, we focus particularly on voice behaviour, what options you need to encourage voice.

And it goes beyond simply telling people they have voice, you have to do really quite specific things. You have to respond in very particular kinds of ways for people who want to give voice. And I think to this day, that is very variable in the NHS.

So a second thing then is that we've been working on systems and processes for reporting concerns formally. And these work very variably well. Sometimes actually going through the process drains the concern of meaning. And the processing then through organisational systems means that, in fact, it begins to lose some of its potency. And I think we still aren't very good at the action at the end of it.

And then there's a third bit of this which is actually about investigations when something has gone wrong. And again, I think this is still done really not very well. So most investigations are not like the ones Bill Kirkup does, most investigations are ones that take place locally, led by a local team. And they will look into an incident of say a drugs overdose or somebody who had…wasn't admitted, didn't get their antibiotics on time, it would be something of that nature, an incident that led to a poor outcome.

And those investigations have to be done within a very particular time period and they're supposed to come up with recommendations for risk controls to address the problem that was seen. And my fantastic colleague Farhad Peerally who is a junior doctor, did his PhD with myself and Graham Martin and some others at Leicester, he showed essentially that the quality of those investigations is not great but what's really, really poor are the risk controls that are recommended. The risk controls don't match the problems that have been identified and they're very often weak, if you look at them as kind of patient safety interventions.

CM: I think, yeah, I can totally, totally relate to that. And you can feel like there's not that continuity. And I think maybe people become a bit disillusioned about that. Is that something that you see when you talk to people about why they're not reporting?

MD-W: I think this issue of a voiceable concern is relevant here. I think the whole business of reporting came in through…from other industries and I don't think was ever sufficiently customised for healthcare. Other industries who are looking at, you know, say aviation, you're looking at mechanical failures and so on where you can actually put a fix in.

Many of the problems in healthcare are actually to do with systems and processes that were just never properly designed. And you need to fix those processes if things are going to go right because they've got built-in weaknesses, they've neve been tested properly and so on.

And the second thing that goes wrong in healthcare is often aspects of culture and behaviour. And basically, the learning about how to do those is there.

So really I think we need to focus more on what do we need to do to fix these systems and processes and what do we need to do to encourage high quality…well, a culture supportive of a really high quality practice.

So there is really excellent literature on what we need to do about cultural improvement and for various reasons, it hasn't penetrated through into healthcare yet. Some of the…and part of it is because the work is really hard work and it gets almost frivolous and something that you should just kind of know anyway. And the reality is, it's the hardest work you'll ever do is to do cultural improvement work. So confronting what you're like as a team or even what you're like as a person, confronting the processes that aren't going really well and doing the work you need to, to improve.

CM: So that was Mary Dixon-Woods. And we'll be hearing more from Mary as we go through the series. And more on what you can expect to hear in a minute, after this.

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CM: So that's it for our first episode. We'll soon be having more of these conversations where we cover important topics that aren't always formally taught. Some of these topics include how to speak up, how to support struggling colleagues, what to do when you make a mistake, both for yourself and for the patient, and what to expect when you get called to inquests.

I'm already so excited about some of the stuff that I'm going to learn from these podcasts and how they're going to help me being a doctor. And if you

are too, you can subscribe to Doctor Informed on Apple Podcasts, Spotify or wherever else you get your podcasts from.

We'll be back in a fortnight with our next episode. So from me, Clara Munro, it's bye for now and we'll see you next time.

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